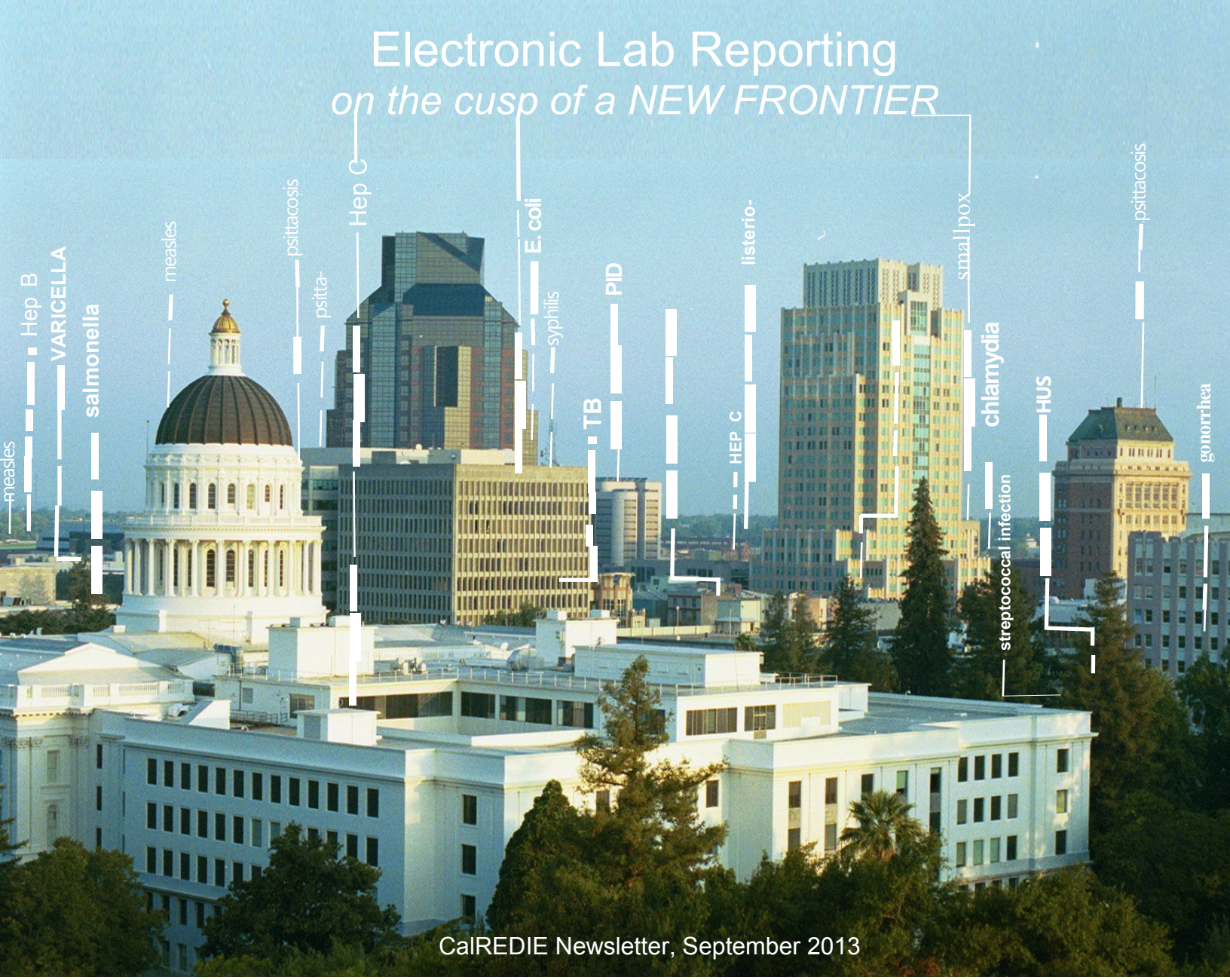
Electronic Lab Reporting

on the cusp of a NEW FRONTIER



CalREDIE Newsletter, September 2013

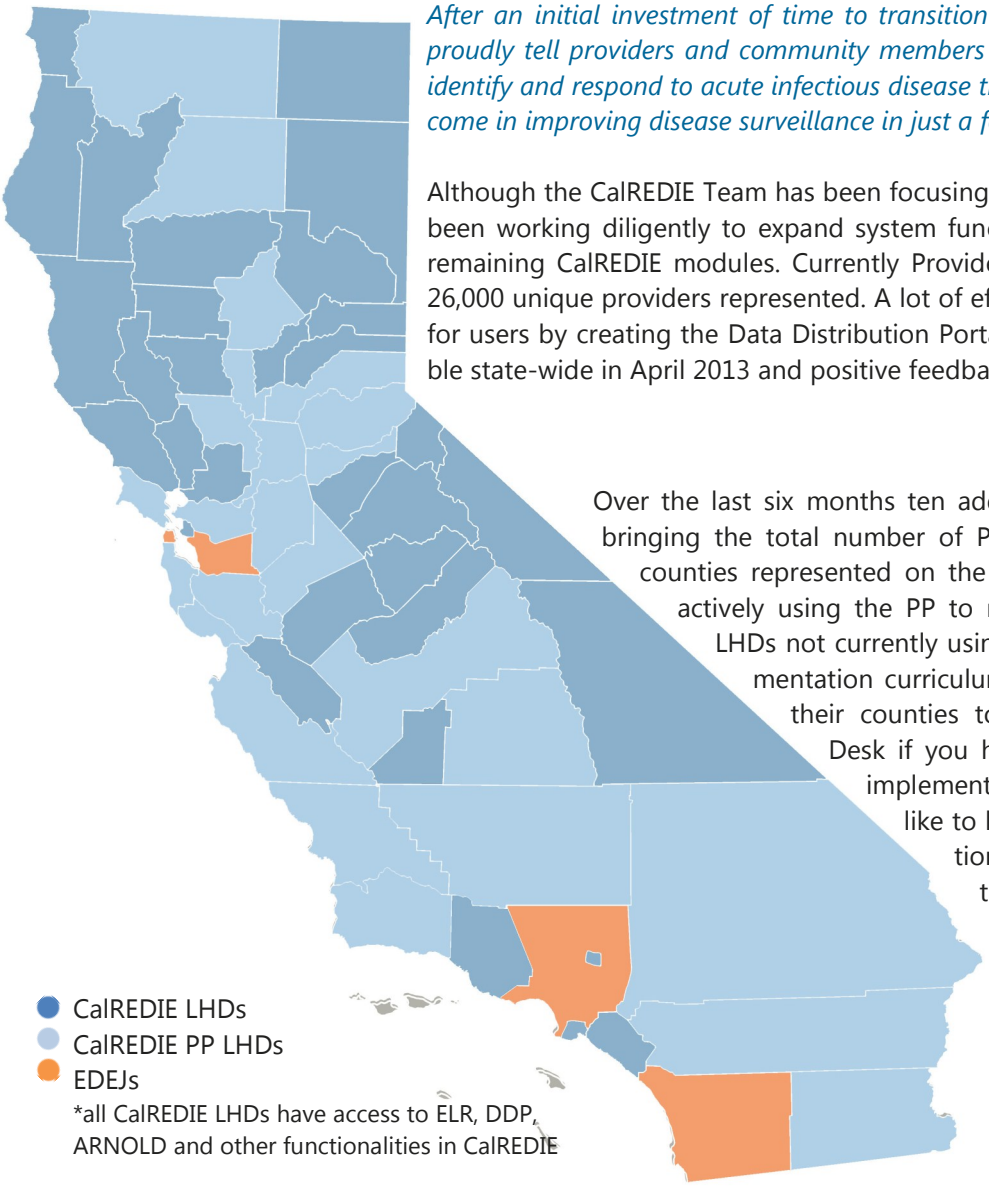
All CalREDIE Newsletter issues are located on the CalREDIE webpage

CalREDIE implementation and expansion

At the Division of Communicable Disease Control (DCDC), our goal is to continue to modernize surveillance systems in California and to standardize and limit data input formats. California Reportable Disease Information Exchange (CalREDIE) system in itself is a major step forward in standardizing data: 57 BLUE Local Health Departments (LHDs) are using CalREDIE as their primary system for disease reporting and surveillance. The ORANGE jurisdictions, our CalREDIE External Data Exchange Jurisdictions (EDEJs), are using CalREDIE for TB and/or STDs. We have engaged in strategic conversations with EDEJs to facilitate data exchange (outside CalREDIE) in the way it is standardized, consistent and compatible with CalREDIE.

A crucial step in modernizing our surveillance systems is to increase electronic data inputs and with the statewide implementation of Electronic Lab Reporting (ELR), we are closer to our goal. We have been receiving live ELR data from several commercial laboratories and hospitals and have been working with pilot counties to confirm that ELR data meet our standards and that it is complete and integrated into our workflows. Dr. Gil Chavez, California State Epidemiologist, reflects on the statewide implementation of ELR: "*The official launch of the CalREDIE Electronic Laboratory Reporting (ELR) module culminates years of planning and hard work. Our joint vision for near real time detection of acute infectious disease threats is closer than ever to becoming a reality. ELR makes it possible to timely monitor laboratory-confirmed notifiable infectious disease while improving our efficiencies and improving data security. Local and state health department staff no longer will have to manually enter data or complete forms, laboratories will report to a single hub for data exchange, and data will be accessible via a centralized repository. Lab results transmitted via faxes and other not secured means will be a thing of the past.*

After an initial investment of time to transition into ELR, each local health department can proudly tell providers and community members that we are better prepared to more quickly identify and respond to acute infectious disease threats. It is quite remarkable how far we have come in improving disease surveillance in just a few years".



Although the CalREDIE Team has been focusing on the implementation of ELR, we have also been working diligently to expand system functionality and support user adoption of the remaining CalREDIE modules. Currently Provider Portal is operating in 25 LHDs with over 26,000 unique providers represented. A lot of effort was also spent in improving data access for users by creating the Data Distribution Portal (DDP). This functionality was made available state-wide in April 2013 and positive feedback indicates that it has been a valuable addi-

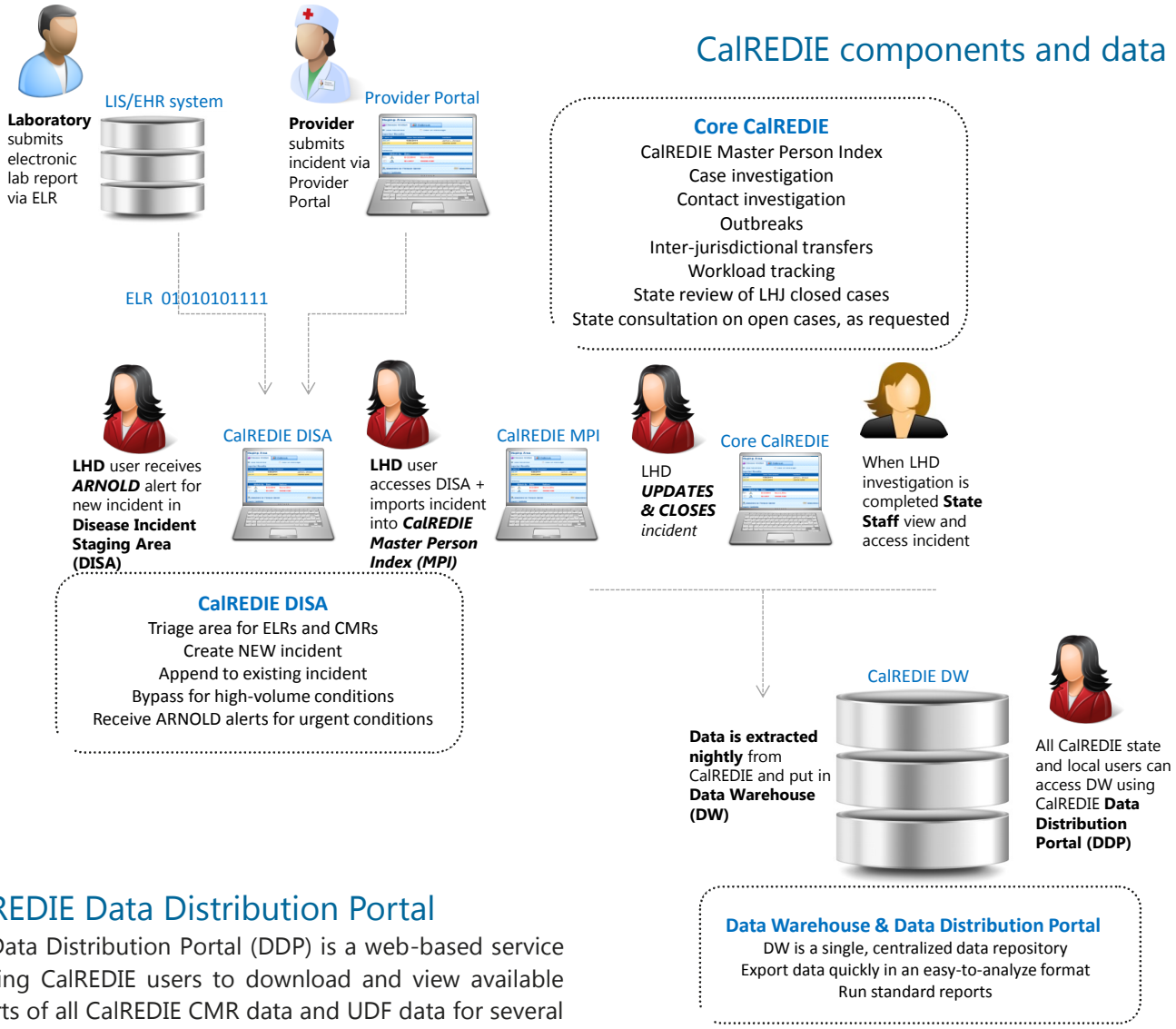
CalREDIE Provider Portal (PP)

Over the last six months ten additional counties have implemented the PP bringing the total number of Provider Portal counties to 25 (LIGHT BLUE counties represented on the map). These counties have 1242 reporters actively using the PP to report cases directly into CalREDIE. Several LHDs not currently using the PP have participated in the PP implementation curriculum and are preparing to recruit providers in their counties to participate. Please contact CalREDIEHelp Desk if you have any PP questions, or are interested in implementing the PP in your jurisdiction. If you would like to learn what is involved in the PP implementation you may review PP reference documentation located on the CalREDIE Help website.

PP usage stats

#LHDs actively using PP:	25
#Reporter accounts:	1242
# Reports received via PP:	32,513
#Reports entered in CalREDIE:	467,751

CalREDIE components and data flow



CalREDIE Data Distribution Portal

The Data Distribution Portal (DDP) is a web-based service allowing CalREDIE users to download and view available exports of all CalREDIE CMR data and UDF data for several conditions. As resources allow, CalREDIE Team continues to roll out additional UDF Exports until all disease conditions are completed.

Who has access to the DDP?

The DDP is available to CalREDIE users with the following user permissions: State Staff, Local Enhanced Staff and Local Staff. Accessing the DDP requires logging in using an 'Active' CalREDIE username and password.

How does the DDP work?

While the interface for the DDP is straightforward and intuitive, there is an introduction video and on-line training tutorial available under the FAQ's section on the DDP navigation menu. Data are exported in a .tsv format and can be imported into a variety of programs for analysis and reporting.

What data elements does the export contain?

For CMR data exports *(e.g. Patient, Case Investigation tabs)* These data exports contain all data elements from the Confidential Morbidity Report (CMR) forms, also known as System Tabs, in CalREDIE.

For UDF data exports *(e.g. Clinical Info., Laboratory Info., Epidemiologic Info., etc.)* These data exports contain all* data elements from both the CMR forms and the User-Defined Forms (UDF) or Case Report Forms for disease-specific conditions. Currently available UDF Exports include: Anthrax, Anaplasmosis/Ehrlichiosis Botulism, Brucellosis, Chlamydia, Dengue, Ehrlichiosis, Hantavirus, Hepatitis A (acute), Gonorrhea, Legionellosis, Leptospirosis, Lyme Disease, Measles, Mumps, Meningitis, Pertussis, PID, Perinatal Hepatitis B, Rocky Mountain Spotted Fever, Typhus and Other Non-Spotted Fever Rickettsioses, Toxic Shock Syndrome and West Nile Virus.

*User Note: UDF exports will NOT contain data (CMR or UDF) for any incidents without at least (1) UDF field completed.

Exports of Incidents containing no UDF data are available through the System Tab Data Extracts.

If you have any questions or are having any trouble accessing the Data Distribution Portal, you may contact the CalREDIE helpdesk at CalREDIEHelp@cdph.ca.gov

HIV/AIDS Reporting

The CalREDIE Team continues collaboration with the Office of AIDS (OOA) to integrate HIV/AIDS reporting into CalREDIE. The technical development team has been working with OOA staff to refine and implement the newly revised Adult HIV/AIDS Confidential Case Report Form (ACR) into CalREDIE. The teams have been working together to enable ELR for HIV lab results, which will greatly simplify the reporting process for laboratories. Beyond these important technical milestones, the OOA is developing legislative policy to streamline case reporting requirements for health care providers and laboratories.

Binational Case Reporting in CalREDIE

The CalREDIE Team has been working with the California Office of Binational Border Health (COBBH) in the Center for Infectious Diseases (CID) to incorporate Binational Case Reporting in CalREDIE, and is excited to announce that we are very close to implementing this functionality in Production! The Binational Case Reporting component will allow COBBH staff to access *only* disease incidents that are marked as binational cases. This is a new type of user access from our usual local and state users that was implemented in V10.

Binational Case Reporting incident access works by allowing a user to mark a case as binational on a user-defined section on the bottom of the Case Investigation tab. This field will then give users with Binational accounts access to the disease incident. Binational Users can only access incidents that are marked as binational. There is also a binational case report form that we are very close to finalizing. This form will be accessed in the Electronic Filing Cabinet (EFC) and be completed for all binational cases.

CalREDIE Team recently held a training session with users from COBBH, San Diego and Imperial counties to review Binational Case Reporting within CalREDIE. Once the form is finalized, these groups will begin a short testing period and when the testing period is complete, the binational case reporting will be available in CalREDIE. Additional updates will be provided on the upcoming Local Users calls.

CalREDIE and HIEs

Leveraging Health Information Exchanges (HIEs) to connect with many small and widely distributed submitters represents an efficient approach to expanding ELR statewide. HIEs focus on smaller health organizations which may lack information systems that are capable of engaging in ELR with CalREDIE. The CalREDIE Team has been collaborating with several active HIEs in California. Most recently two (HIE) organizations: Redwood Mednet and Inland Empire HIE are starting the testing phase of the ELR onboarding progression. Richard Swafford, PhD, Executive Director at Inland Empire Health Information Exchange (IEHIE) is excited to share with the CalREDIE Newsletter audience: *"On June 28, 2013, IEHIE sent the first successful test ELR message from IEHIE to CalREDIE. We look forward to continuing the progress made to this point and we are anxiously awaiting ELR connection for IEHIE subscribers, including Riverside County PHL, and other clients in San Bernardino and Joaquin Counties."*

CalREDIE and Public Health Labs (PHLs)

Over a year ago, the CalREDIE Team reached out to the California Association of Public Health Laboratory Directors (CAPHLD) in an effort to marshal the local public health labs for electronic laboratory reporting (ELR). It quickly became apparent that widespread resource constraints posed a significant obstacle to configuring lab information systems to produce ELR. Rick Alexander, CAPHLD President, comments on the readiness of Public Health labs to send ELR: *"In 2012, the CAPHLD surveyed all of the public health laboratories in California as to their readiness for ELR. Of the 38 Public Health labs, none were ready to transmit ELR. There were 10 different LIS's being used by 32 labs. Six labs had no LIS. There were 12 labs that used the same vendor, Apollo."*

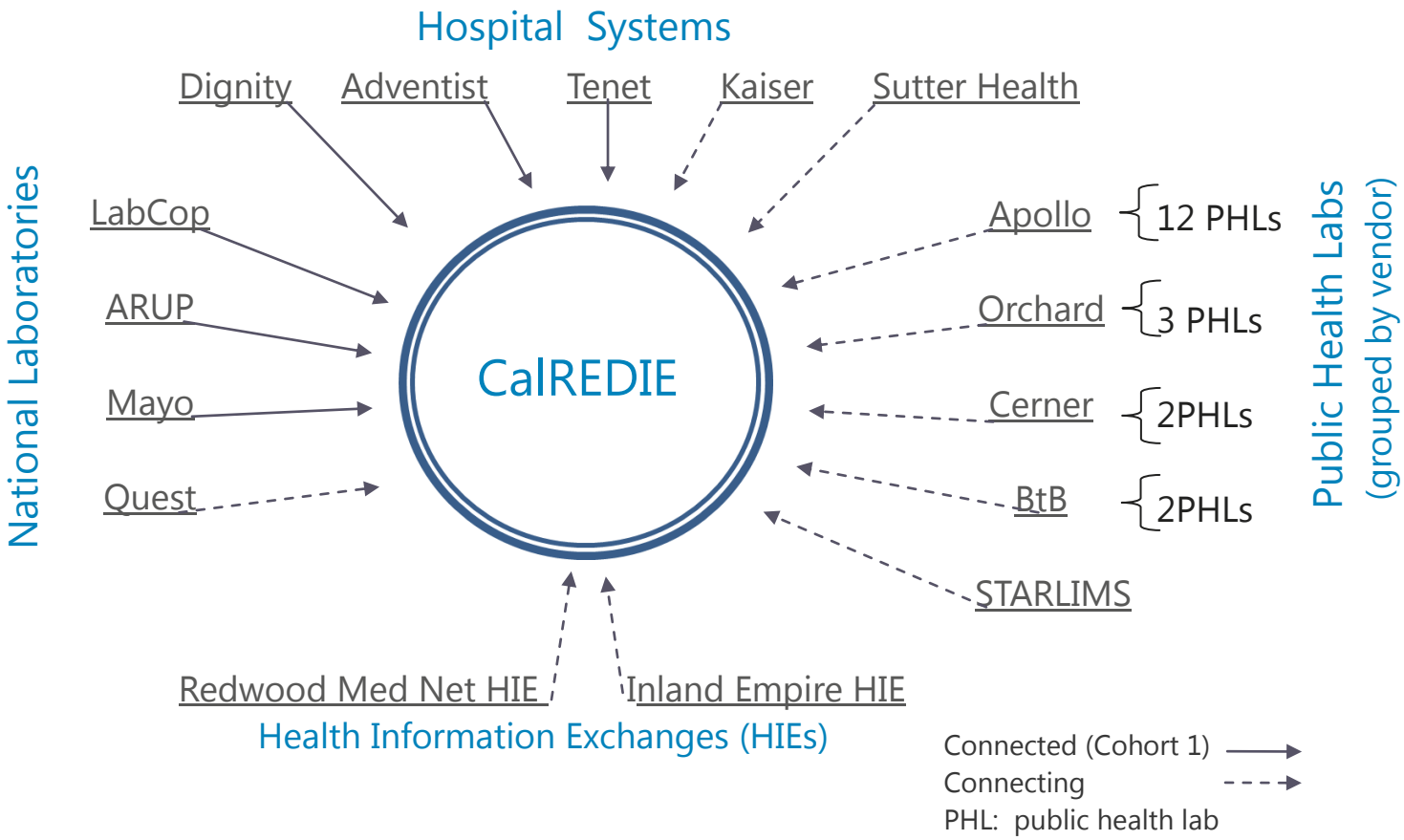
CalREDIE worked with CAPHLD President Rick Alexander and Long Beach Public Health Lab Director Mimi Lachica to first identify opportunities to overcome technical obstacles with 12 labs using ApolloLIMS. One of these obstacles was the lack of LOINC and SNOMED coding. In order to move the coding process forward, the CalREDIE Team worked with each lab to compile its test compendium for a technical assistance request to Centers for Disease Control and Prevention (CDC) and APHL. This coding technical assistance is scheduled to begin shortly. Following completion of coding, ELR technical testing from the PHLs begins.

Regarding other PHLs, Orange County PHLs is using Cerner HealthSentry and they have demonstrated ELR competency in other installations. Rick Alexander provides further insight: *"The Orange County Public Health Laboratory uses the Cerner LIS. Cerner estimated a cost of over $30,000 to add ELR to the system. Fortunately, in 2013, the Cerner contract was expanded by Behavior Health and included EHR. Within the EHR upgrade was a provision for establishing ELR. The Public Health Laboratory is now actively working with County IT and Cerner to implement ELR to CalREDIE with no additional County costs. ELR should be up and running in 2013"*

Another handful of PHLs are developing HL7 interfaces through their installation of Orchard Software. Lastly, we have a group of public health labs that are using BtB software and, according to BtB, they are also ready to engage in ELR with CalREDIE.

Selected CalREDIE ELR SUBMITTERS, August 2013

Complete and updated list can be found on the CalREDIE ELR webpage



ELR pilot: goals and discoveries

Electronic Laboratory Reporting (ELR) represents several significant changes to public health in California. The CalREDIE Team built a completely new way to programmatically digest, transport, and route reportable lab results to the appropriate LHD, so we needed to pilot the system to ensure that it was working properly. We needed to learn how ELR affected the way submitters sent reports, the way LHD received reports, and most importantly, we needed to understand how to help all LHDs accommodate changes in business processes. CDPH had several goals for the ELR pilot:

- Allow CalREDIE Team to understand the intake technical and business process differences and to exercise ELR handling with live data in a practice environment.
- Allow CDPH to perform Quality Control (QC) on incoming statewide ELR feeds, including 100% ELR—Fax comparison for several months
- Allow CDPH to check and confirm proper operation of technical systems upstream of CalREDIE (SFT, Rhapsody, CalREDIE Lab Intake Module)
- Allow LHDs to adapt their business process from fax to ELR and share adaptations with other jurisdictions
- Allow LHDs to perform QC on their ELR feed

Initially, we worked with a medium-sized hospital as an early ELR pilot, but they had some significant challenges with their EHR. Based on recommendations from CDC and the national labs' reputation for ELR proficiency, CDPH refocused the ELR Pilot on LabCorp, ARUP, and Mayo. These national labs used a messaging standard refined through their previous work with CDC and other states. Before and during the ELR pilot, the CalREDIE Team performed quality analysis on the incoming ELR feeds. This included performing a statewide 100% comparison of incoming ELR to the incoming fax reports for the national lab submitters over a selected 60-day time-frame. In addition, ELR pilot was an opportunity to take a live feed to refine and tune the health integration engine which performs automated message validation, automated message response, and automated message routing. Perhaps most importantly, we were able to measure the impact of several diseases with high-volumes of lab reports. Based on this finding, CalREDIE Team and ELR Pilot partners were able recommend automated processing for incoming lab reports for four diseases.

Submitted by Michele Cheung, MD MPH, on behalf of Orange County Health Care Agency

Orange County was invited to participate in a CDPH pilot with LabCorp in the fall of 2012 and testing began in January of 2013. Between 1/28-6/6/13 (~19 week period), Orange County received over 5000 ELRs and almost 1300 faxed paper lab reports. For the pilot, depending on the week, approximately five staff members were involved, including epidemiologists, research analysts, office staff, and a medical officer, spending in total about 15-20 hours per week. Goals in testing were to match up the ELR to the faxed paper report, track numbers of reports, and ensure imported laboratory data was accurate. Testing occurred daily to 1-2 times per week depending on the staff person, their assignment and other workload.

ELRs came in general on the same day or earlier than the faxed paper reports. Timeliness of reports was greatly increased for Orange County residents that were seen by health care providers in another county. However, at times delays in ELR results were noted for some patients without complete address information or an incorrect zip code. The screening out of non-resident ELRs was excellent and reports on out-of-county residents were not received except when the zipcode was once shared with Orange County. Towards the end of the pilot study, generally all expected ELRs were received in the system. Overall, the reliability and accuracy of ELR messages corresponding to the paper copy records was excellent.

With regards to duplicate ELRs being received, these became problematic when a new lab report was attached to only one of these records, leaving one record with incomplete information. In addition, a significant delay in ELRs was noted on a day the transmission from LabCorp failed, leading to our recommendation that an alerting mechanism be established to recognize when transmissions have not arrived, which CDPH is addressing. The ELR submitting partner (LabCorp) was also very willing to improve their submissions, discuss issues and questions, and seemed quite experienced in ELR.

The ELR laboratory tab within the system (i.e. the naming of the variables) was not intuitive for our clinical or epidemiological staff and will require additional staff training. However, CDPH has created an ELR User Guide that addresses some of these issues.

During the pilot testing, a large increase in laboratory reports was noted with ELR, with the greatest increases among the highest volume reportable diseases. For Orange County, this is a very significant concern at the current time since the high volume diseases will clutter the DISA inbox if not auto-processed. Orange County awaits the completion of the pending items and the CACDC survey about auto-processing to determine how usable the system will be for us, but overall we feel ELR has the potential to increase the timeliness of reporting in general by 1 to 2 days, save considerable paper, filing cabinet space and staff time.

Submitted by Barbara Cole on behalf of Riverside County

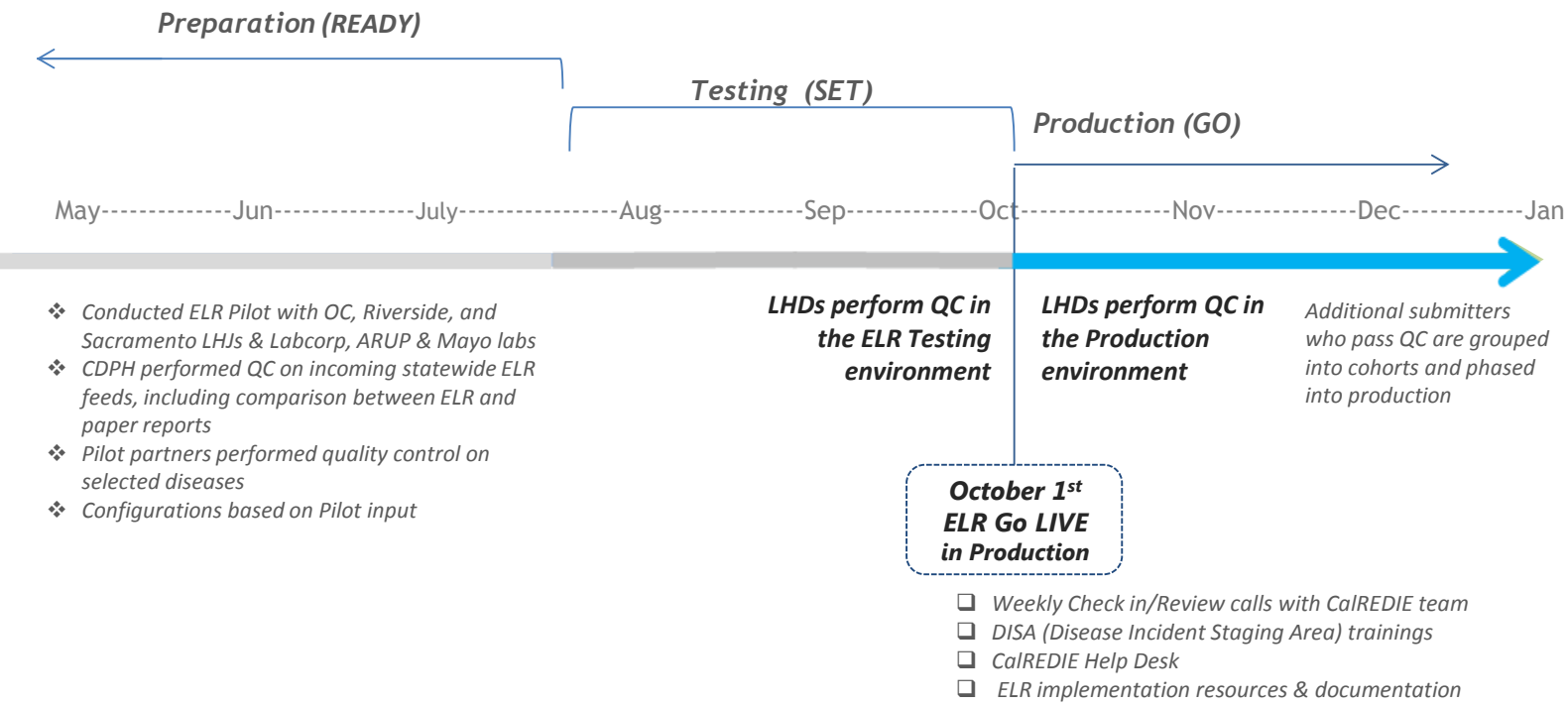
The ability to have diseases automatically imported from ELR into CalREDIE proper, has the potential of decreasing the workload at the local level. During the validation process, it did take quite of bit of time to review the various labs that were received, and compare them to the regular lab results. All of the labs were not able to be matched. My workload prohibited review of the labs on a daily basis, so reviewing was done approximately two times per week. For LHDs it will be important to consider the impact on the program and staff when ELR is fully implemented.

Participation in the recent pilot identified some key issues that should be considered in preparation to implement ELR:

1. It is important to have staff who are well-versed in the use of CalREDIE.
2. It is important to compare your "as is" workflow to the process for ELR (e.g. role of clerical staff vs. Nurses; Epi)
3. Consider which diseases you want "ARNOLD" alerts on and impact of these on your e-mail.
4. Policy issues around receiving negative lab results for specified diseases(e.g. r/o measles- where the test may be gone at a commercial lab rather than a PHL) Legal aspects of requesting that labs report negative lab results for designated diseases need to be addressed at the state level.
5. How will sequential labs be handled (e.g. positive AFB smear, followed by negative for clearance; Positive Salmonella, with subsequent negatives needed for clearance of people in SOS.)
6. Which diseases will be auto-processed and auto closed? Are LHDs able to still access closed records?

It is important to use the current "test" period to become familiar with ELR, so informed decisions can be made about implementation at the local level.

CalREDIE ELR Implementation: target Go Live October 1st



ELR Implementation timeline

The first cohort of ELR submitters (consisting of three national labs: LabCorp, ARUP and Mayo) is scheduled to roll into the CalREDIE Production Environment in October. This group represents considerable depth and breadth of ELR experience in other states and territories. Many following cohorts of labs will join ELR as we move forward (please refer to the visual on page 10)

User acceptance testing (UAT) has been expanded to all CalREDIE LHDs. UAT or Testing phase extends through September 30th for this cohort of submitters. This means that LHDs are able to see, review, and perform quality control on the live ELR feed, which is directed to a special ELR testing environment. In addition, ELR testing presents an opportunity for the LHDs to check and adapt their local business processes to successfully transition from paper/fax based lab reporting to electronic lab reporting through CalREDIE.

Following a successful Testing Phase, the first cohort will be rolled into production (target Go Live—October 1st, 2013). This means that live ELR feeds will flow into the CalREDIE production system and LHD staff can use live, production-quality ELR data to instantiate cases. When operations are running smoothly in production, CDPH & LHDs will be able to consider the decision to direct the first cohort of submitters to cease paper laboratory results.

Following the first cohort, the CalREDIE Team will organize additional lab submitters into succeeding cohorts to progress into testing and ultimately into production before the first business day of each quarter.

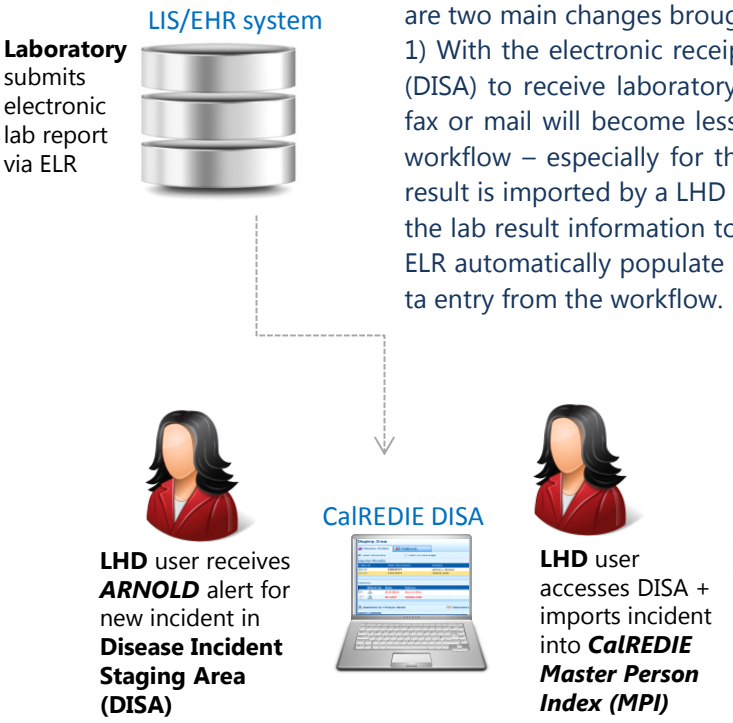
ELR Testing phase

On August 12th we launched the Testing Phase of a long awaited Electronic Lab Reporting. Active participation in the Testing Phase will allow your LHD to prepare for the transition to ELR. During the Testing Phase, LHDs will be able to assess and identify the impact that this transition will have on your LHD in a "risk-free" environment. The goals of the Testing phase are to provide LHD Staff an opportunity to:

- become familiar with the new aspects of CalREDIE that ELR introduces including use of the DISA and population of the lab data on the lab tabs.
- inform and guide how LHDs change your business process from fax/paper to ELR
- determine what the impact of the receipt of ELRs for high volume diseases is on your LHD, which in turn will help inform your decision on auto-processing
- conduct QC on the ELR data.

What does the transition mean for your LHD?

As expected and learned firsthand during the ELR pilot – implementation of electronic lab reporting represents a change in the business process or workflow at the local level. There are two main changes brought about by electronic lab reporting in CalREDIE:
1) With the electronic receipt of data, LHDs will use of the Disease Incident Staging Area (DISA) to receive laboratory result information; paper based reports that you receive via fax or mail will become less and less useful. Using the DISA is the first major change in workflow – especially for those LHDs that have not used Provider Portal. 2) When a lab result is imported by a LHD user in the DISA, the user can create a new incident or append the lab result information to an existing incident. In this import process, the lab data from ELR automatically populate certain sections within the incident, removing much of the data entry from the workflow.



How can your LHD prepare for and manage this transition?

As with any business process change, recognizing and preparing for the change will minimize the impact. We recommend that LHDs think about the following items and plan for the ELR transition:

Based on experiences of our ELR pilot LHDs and ELR experiences in other states, LHDs should prepare for an increase in the number of lab reports received. One of the lessons learned from the ELR Pilot was that more than one person should be responsible for managing the records that are received in the DISA.
We recommend that LHDs develop a strategy for managing the DISA, and think about:

- Who will be responsible for checking the DISA
- How frequently? Weekly? Daily? 2x/day?
- How will the records be divided among staff?

Another consideration is the learning curve associated with interpreting the lab result data displayed to users in the lab system section on the Lab Tabs. CalREDIE Team provides several resources to assist LHDs in using the Lab tab, DISA. and other ELR related functionalities in CalREDIE. As part of your ELR preparation activities, we recommend reviewing the materials and documentation that CalREDIE Team has prepared including:

- **DISA Training** – Several webinars on the use of the DISA have been hosted, and a recording is available on the Locals Users webpage
- **ELR User Guide** – Among other information includes a how-to guide for managing records in the DISA and a complete field mapping of the fields that are populated based on an ELR.
- **ELR Quality Control Guide** – The ELR QC guide is a recommended protocol for comparing ELR to paper reports

QC protocol

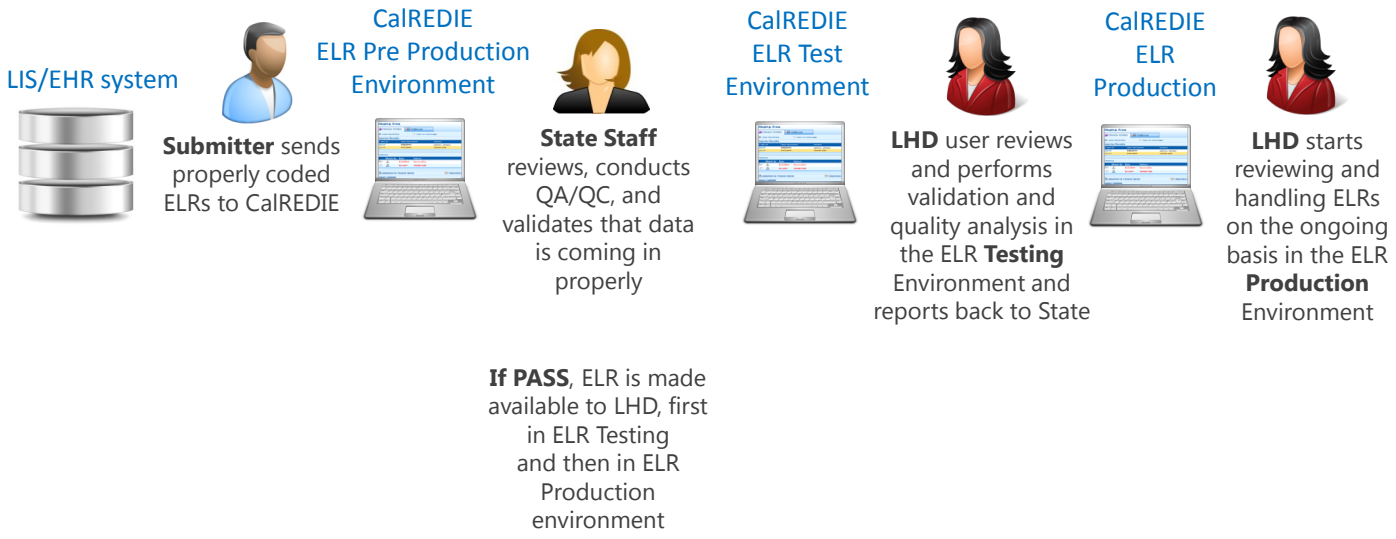
CDPH has developed a *recommended* protocol for QC of the ELR data for LHDs to use in deciding to what extent they will check incoming ELR. It is left to each LHD to determine how much time and staff resources to devote to comparing the ELRs received to paper reports received. During the pilot phase, our three LHDs approached QC differently, and we expect that each LHD will have their needs and resources to take into account when deciding the approach.

Proposed LHD Action item-check list – ELR Testing Phase

⇒ Each LHD should designate an ELR Liaison (or two) and submit those names to CalREDIEHelp
⇒ Obtain an ELR Testing Accounts for staff that will be participating
⇒ Review the ELR Documentation posted on the CalREDIE Help webpage
⇒ Develop a plan for how your LHD is going to conduct QC as well as manage the DISA.
⇒ Practice reviewing/handling the ELRs in the testing environment
⇒ Plan to attend the weekly check-in calls on Tuesday afternoons from 2:00-3:00pm

Shared responsibility in progressing submitter cohorts to production

State and LHDs share responsibilities in progressing submitter cohorts to production. The submitter conducts quality control (QC) to ensure regulatory compliance. The CalREDIE Team validates that data are coming in properly, reviews message exceptions, and conducts analysis to identify when the submitter falls outside of its regular reporting pattern. The LHDs may conduct QC to compare reports received via paper vs. reports received via ELR and manage individual data in DISA.



From the submitter perspective, the ELR onboarding process consists of enrollment and secure connection, engagement in mechanical ELR message testing until the messages pass HL7 validation, and then sending a live feed into ELR test, where the CalREDIE Team reviews the feed for content, quality, and reliability.

At the state level, incoming messages go through a program-driven, automated structural validation scheme. ELR messages are parsed and analyzed in order to determine whether the reported item is allowed in CalREDIE and whether the reported item belongs within a jurisdiction using CalREDIE. Reports for EDEJs are routed outside of CalREDIE directly to the appropriate EDEJ. Then the CalREDIE Team performs quality control measures for incoming lab messaging on the basis of the mechanics of messaging and data flow.

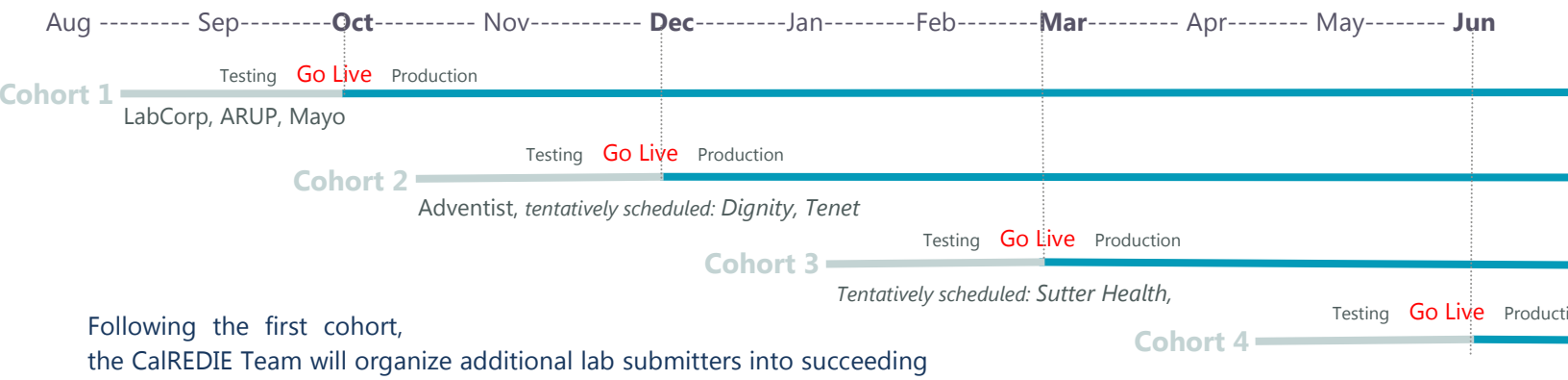
Selected QC activities which are performed at the State level:

- CalREDIE Team compares the number of messages arriving to the number of messages flowing into CalREDIE, while noting discrepancies and investigating the reason for any differences.
- CalREDIE Team reviews message exceptions/errors captured in the automated intake.
- An algorithm based monitor detects and alerts system administrators when a submitter falls significantly outside of its established ELR submission pattern. When this occurs, CalREDIE Team contacts the submitter for further information.

From the LHD perspective, after the CalREDIE Team has reviewed the ELR feed in test for several weeks for quality and reliability, the LHD can perform UAT, analyzing the ELRs for fidelity against lab reports arriving via more traditional methods, such as fax and mail. There is a spectrum of quality control measures: At one extreme LHD can choose to check 100% of incoming fax against ELR. At the other extreme, the LHD can choose not to check fax against ELR at all. The ideal is somewhere in between and each LHD will need to assess where it wants to focus limited time and resources. Different diseases may demand different levels of scrutiny.

When the LHD, the CalREDIE Team, and the submitter have collectively decided that the ELR feed is ready to roll into production, the CalREDIE Team will move a logical switch to direct the ELR feed from ELR test to production. When the LHD is satisfied that the ELR system is operating smoothly for this particular submitter, the LHD can consider the decision to direct the submitter to cease paper/traditional reporting.

Scheduled Submitter Cohorts 1 through 4



Following the first cohort, the CalREDIE Team will organize additional lab submitters into succeeding cohorts to progress into testing (user acceptance testing (UAT) and ultimately into production on the first business day of the quarter.

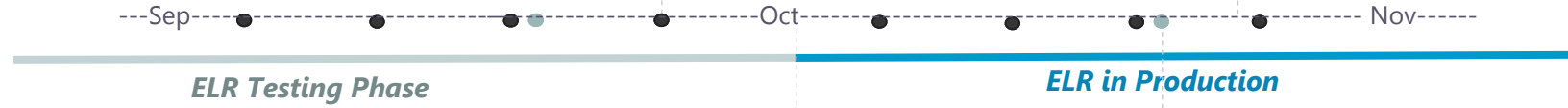
Cohort 1 started ELR UAT mid-August; scheduled to roll into production at the beginning of October 2013.
Cohort 2 scheduled to start ELR UAT mid-October; scheduled to roll into production at the beginning of December 2013.
Cohort 3 scheduled to start ELR UAT mid-January 2014; scheduled to roll into production at the beginning of March 2014.
Cohort 4 scheduled to start ELR UAT mid-April 2014; scheduled to roll into production at the beginning of June 2014.

Transitioning to ELR – Collaboration venues

As we move forward over the next several months, we want to ensure that you are aware of the various venues that are available for State and Local collaboration on ELR related activities and issues:

ELR statewide Check In Call (Before we move ELR to Production)
(Tuesday, September 24th)
Lessons Learned from the ELR Testing Phase
Review issues that came up during the Testing Phase
Discuss next steps to moving to Production
Discuss submitters cohorts progression plan (from Enrollment to Production)

ELR update for health officers, CCLHO Semiannual meeting
(October 23rd)
Provide ELR Implementation update
Discuss submitters cohorts progression—decisions points (from Enrollment to Production)



ELR Testing Phase

ELR in Production

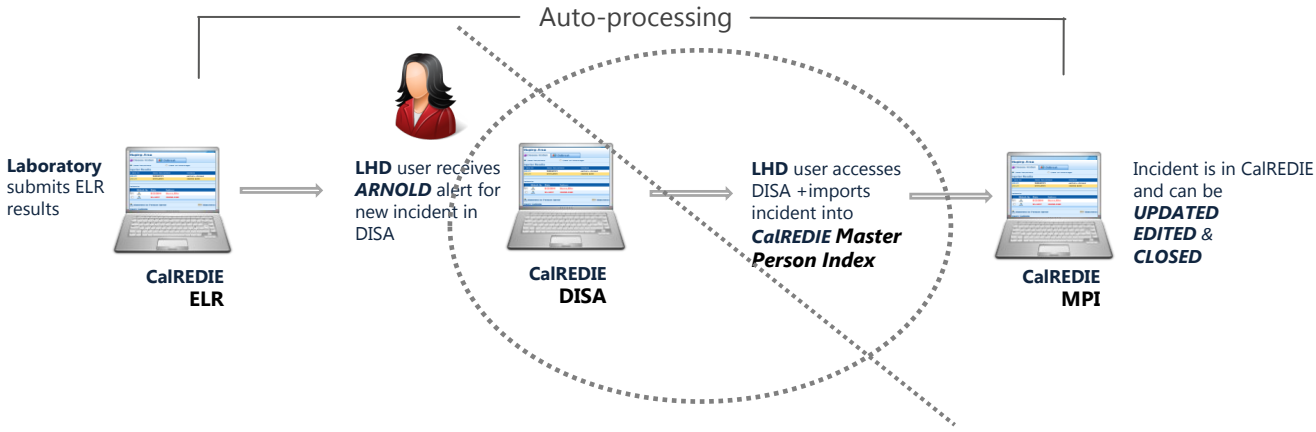
- **ELR weekly Check in Calls** (Tuesdays 2:00-3:00pm)
- **CalREDIE monthly Local Users call** (third Wednesdays 9:00-10:30pm)

ALL CalREDIE LHDs
Target ELR Go Live in Production
(October 1st)

ELR Advisory Team meeting
(state & local users, CCLHO affiliate org. representatives)
Discuss strategic and policy issues that affect ELR

ELR Advisory Team meeting: This will be a venue for state and local users and representatives from the CCHLO affiliate organizations to discuss strategic and policy issues that affect ELR.
ELR statewide Check in Meeting: Our last ELR check in call in September (before ELR Go live) will be dedicated to sharing lessons learned from the ELR Testing Phase, reviewing issues that came up during the ELR Testing Phase an discussing next steps to moving to Production.
CalREDIE monthly Local User Call and **ELR weekly Check-in Call** are venues where we meet with local users to provide updates on the various aspects of the CalREDIE and ELR efforts. This is a venue for local users to ask questions, voice concerns or share other comments with state staff and other local users.

Within CalREDIE, it is possible to "turn-on" what is called Auto-processing. Auto-processing means that the ELR result bypasses the DISA and goes directly into the CalREDIE master person index (MPI). This provides an opportunity for automated operations on incoming high volume selected disease reports. Based on ELR volumes for selected diseases, auto-processing is a crucial feature that will allow local epidemiology staff to focus on the remaining lab reports which may require more case-level attention and investigation.



One of the strengths of CalREDIE is that the auto-processing functionality is configurable. This means that we can control how the auto-processing works. There are three ways in which auto-processing can be configured: by Disease, by Process Status and by Resolution Status.

Main Points to Understand About Auto-processing

- Auto-processing is NOT configurable by jurisdiction. Auto-processing must be applied across the entire CalREDIE system and cannot be tailored differently for each LHD at this time. CalREDIE Team is working with LHD staff to support discussion regarding auto-processing of high-volume lab reports by disease. Automated handling for a few selected diseases is under-consideration.
- Auto-processing is configurable by disease.
- The Process Status and Resolution Status can be automatically assigned.
- Auto-processing reduces the number of results the local user must review in the DISA.
- Anything that is auto-processed can easily be accessed in the CalREDIE MPI, regardless of the Process Status or Resolution Status that is assigned.
- LHDs staff will be able to use the Data Distribution Portal to generate reports specific to auto-processing.

CalREDIE Help webpage contains various reference materials including the Factsheet on Auto-processing. If you have any questions regarding the auto-processing please contact CalREDIEHelp@cdph.ca.gov.

Learn how Auto processing works during the ELR Testing Phase

Auto-processing was turned OFF at the beginning of the ELR Testing Phase. On August 26th, we turned auto-processing ON for the following diseases:

Chlamydia – is being auto-imported then auto-confirmed and auto-closed (i.e. Process Status = "Closed by LHD" and Resolution Status = "Confirmed").
Gonorrhea – is being auto-imported only (i.e. Process Status = "Entered" and Resolution Status = "Suspect")
Hepatitis C – is being auto-imported then auto-confirmed and auto-closed (i.e. Process Status = "Closed by LHD" and Resolution Status = "Confirmed").
Hepatitis B – is being auto-imported only (i.e. Process Status = "Entered" and Resolution Status = "Suspect")

Please remember that the auto-processing configurations above are *only for the Testing phase*. This is an opportunity for local users to experience how auto-processing operates and get familiar with the different types of auto-processing. The decision for which diseases to auto-process when we go-live with ELR is still under discussion.